

Statement
of the
American Medical Association
to the
Subcommittee on Health and Environment
Committee on Commerce
U.S. House of Representatives
Assisted Suicide: Legal, Medical, Ethical and Social Issues

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My name is Lonnie R. Bristow, MD. I practice internal medicine in Sao Pablo, California, and I also serve as the Immediate Past President of the American Medical Association (AMA). On behalf of the AMA, I appreciate the opportunity to present our views on physician-assisted suicide to this Subcommittee and to express our support for legislative efforts to bar the use of federal monies for "assisted suicide."

For nearly 2,500 years, physicians have vowed to "give no deadly drug if asked for it, [nor] make a suggestion to this effect." What has changed, that there should be this attempt to make "assisted suicide" an accepted practice of medicine? Certainly the experience of physical pain has not changed over time. Yet the blessings of medical research and technology present their own new challenges, as our ability to delay or draw out the dying process alters our perceptions and

needs.

Our efforts in this new paradigm must recognize the importance of care that relieves pain, supports family and relationships, enhances functioning, and respects spiritual needs. Calls for legalization of physician-assisted suicide point to a public perception that these needs are not being met by the current health care system. In addition, society has not met its responsibility to plan adequately for end-of-life care. It is this issue -- how to provide quality care at the end of life -- which the AMA believes should be our legitimate focus.

The AMA believes that physician-assisted suicide is unethical and fundamentally inconsistent with the pledge physicians make to devote themselves to healing and to life. Laws that sanction physician-assisted suicide undermine the foundation of the patient-physician relationship that is grounded in the patient's trust that the physician is working wholeheartedly for the patient's health and welfare. The multidisciplinary members of the 1994 New York State Task Force on Life and the Law concur in this belief, writing that "physician-assisted suicide and euthanasia violate values that are fundamental to the practice of medicine and the patient-physician relationship."

Yet physicians also have an ethical responsibility to relieve pain and to respect their patient's wishes regarding care, and it is when these multiple duties converge at the bedside of a seriously or terminally ill patient that physicians are often torn.

The AMA believes that these additional ethical duties require physicians to respond aggressively to the needs of the patients at the end of life with adequate pain control, emotional support, comfort care, respect for patient autonomy and good communications.

Further efforts are necessary to better educate physicians in the areas of pain management and effective end-of-life care. Patient education is the other essential component of an effective outreach to minimize the circumstances which might lead to a patient's request for physician-assisted suicide: inadequate social support; the perceived burden to family and friends; clinical depression; hopelessness; loss of self-esteem; and the fear of living with chronic, unrelieved pain.

ETHICAL CONSIDERATIONS

Physicians' Fundamental Obligation: The physician's primary obligation is to advocate for the individual patient. At the end of life, this means the physician must strive to understand the various physiological, psychological and existential factors that play out over the course of terminal illness and must help the patient cope with each of them. Patients who are understandably apprehensive or afraid of their own mortality need support and comforting, not a prescription to help them elude the issues of approaching death. Patients who believe sudden and "controlled" death would protect them from the perceived indignities of prolonged deterioration and terminal illness must receive social support as well as the support of the profession to work

through these issues.

Pain Management and the Doctrine of Double Effect: Many proponents of assisted suicide cite a fear of prolonged suffering and unmanageable pain as support for their position. For most patients, advancements in palliative care can adequately control pain through oral medications, nerve blocks or radiotherapy. We all recognize, however, that there are patients whose intractable pain cannot be relieved by treating the area, organ or system perceived as the source of the pain. For patients for whom pain cannot be controlled by other means, it is ethically permissible for physicians to administer sufficient levels of controlled substances to ease pain, even if the patient's risk of death is increased.

The failure of many states to expressly permit this practice has generated reluctance among physicians to prescribe adequate pain medication. Additional uncertainty is produced by the potential for legal or licensure action against the physician when controlled substances are prescribed in large amounts to treat patients with intractable pain. This uncertainty chills physicians' ability to effectively control their terminally ill patients' pain and suffering through the appropriate prescription and administration of opiates and other controlled substances. In this area, states such as California and Texas have developed clear legislative guidance that resolves these concerns for most physicians. The AMA has developed similarly structured model legislation for state medical societies to pursue with their state legislatures and medical licensing boards.

In some instances, administration of adequate pain medication will have the secondary effect of suppressing the respiration of the patient, thereby hastening death. This is commonly referred to as the "double effect." The distinction between this action and assisted suicide is crucial. The physician has an obligation to provide for the comfort of the patient. If there are no alternatives but to increase the risk of death in order to provide that comfort, the physician is ethically permitted to exercise that option. In this circumstance, the physician's clinical decision is guided by the intent to provide pain relief, rather than an intent to cause death. This distinguishes the ethical use of palliative care medications from the unethical application of medical skills to cause death.

Distinction Between Withholding or Withdrawing Treatment and Assisted Suicide: Some participants in the debate about assisted suicide see no meaningful distinction between withholding or withdrawing treatment and providing assistance in suicide. They argue that the results of each action are the same and therefore the acts themselves carry equal moral status. This argument largely ignores the distinction between act and omission in the circumstances of terminal care and does not address many of the principles that underlie the right of patients to refuse the continuation of medical care and the duty of physicians to exercise their best clinical judgment. Further, it rides roughshod over the long-held recognition in common law of an individual's right to prevent intrusions upon his or her person.

Specifically, proponents who voice this line of reasoning fail to recognize the crucial difference

between a patient's right to refuse unwanted medical treatment and any proposed right to receive medical intervention which would cause death. Withholding or withdrawing treatment allows death to proceed naturally, with the underlying disease being the cause of death. Assisted suicide, on the other hand, requires action to cause death, independent from the disease process.

The "Slippery Slope": Physician-assisted suicide raises troubling and insurmountable "slippery slope" problems. Despite attempts by some, it is difficult to imagine adequate safeguards which could effectively guarantee that patients' decisions to request assisted suicide were unambivalent, informed and free of coercion.

A policy allowing assisted suicide could also result in the victimization of poor and disenfranchised populations who may have greater financial burdens and social burdens which could be "relieved" by hastening death. As reported three years ago by the New York State Task Force on Life and the Law (composed of bioethicists, lawyers, clergy and state health officials), "[a]ssisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care."

Recent studies documenting reasons for patient requests for physician-assisted suicide speak to our "slippery slope" concerns. Patients were rarely suffering intractable pain. Rather, they cited fears of losing control, being a burden, being dependent on others for personal care and loss of

dignity often associated with end-stage disease.

The Case of the Netherlands: While euthanasia and assisted suicide are not legal in the Netherlands, comprehensive guidelines have been established which allow physicians to avoid prosecution for the practice. Despite this environment, Dutch physicians have become uneasy about their active role in euthanasia, prompting the Royal Dutch Medical Association to revise its recommendations on the practice.

Findings, according to one major study, of more than 1,000 cases of involuntary euthanasia in the Netherlands should raise hackles in the United States, particularly given the stark societal differences between the two countries. Health coverage is universal in the Netherlands, the prevalence of long-term patient-physician relationships is greater and social supports are more comprehensive. The inequities in the American health care system, where the majority of patients who request physician-assisted suicide cite financial burden as a motive, make the practice of physician-assisted suicide all the more unjustifiable. Further, a five-year follow-up of the Netherlands case, reported in the *New England Journal of Medicine*, demonstrated that even strong and open regulation of physician-assisted suicide does not improve the rate of abuse (if anything, the rate showed a marginal increase). Aside from the Northern Territory of Australia, no other country in the world, including the Netherlands, has actually legalized assisted suicide or euthanasia. This is one movement in which the United States should not be a "leader."

EDUCATING PHYSICIANS AND PATIENTS

Over a year ago, the AMA House of Delegates adopted recommendations from a report issued by its Task Force on Quality Care at the End of Life. The report identified issues involved with care of the dying, including the need to develop a definition of "futility," provision of optimal palliative care, legislation ensuring access to hospice benefits, and the importance of advance care planning as a part of standard medical care. Based on the report's recommendations, the AMA is coordinating its current efforts and developing a comprehensive physician and patient education outreach campaign regarding quality of care at the end of life.

The AMA is uniquely capable of educating physicians and other caregivers, legislators, jurists, and the general public as to end of life care issues. Recognizing the profession's desire to structure discussions of end-of-life care and maintain an active and improved role in the care of dying patients, the AMA has embarked on a comprehensive physician education outreach, with assistance from the Robert Wood Johnson Foundation, to rectify identified inadequacies in the quality of patient care available for individuals at the end of life. The AMA plans to implement a two-part physician education program that ultimately will incorporate advance care planning into routine patient care activities, similar to the incorporation of a medical history as one of the routine patient care activities that serve as a cornerstone for patient care decisions and

determinations. The program will also integrate palliative medicine as a beneficial and accepted care option within the physician's armamentarium. In fostering such communication, the AMA is particularly concerned with enabling physicians to support patient autonomy, providing patients with sufficient background and support to make informed decisions regarding their end-of-life treatment. The program is designed to reach every physician in America over the next few years.¹

Through continued educational efforts, physicians are committed to demonstrating their enduring commitment to providing the best patient care during every stage of life. Furthermore, provided the tools to facilitate improved terminal care, physicians can readily answer many of the arguments of assisted suicide's proponents.

MEDICARE AND MEDICAID COVERAGE

¹ Our activity in educating physicians and their patients on end-of-life issues is a component of our Association's broader initiative on professionalism and ethics, AMA's Institute for Ethics. The Institute, to be officially launched at our ethics symposium in Philadelphia next week, will focus on, but not be limited to, ethical and practical issues in four major areas of concentration: end-of-life care, genetics, managed care and professionalism. The Institute will work closely with the AMA's Council on Ethical and Judicial Affairs (CEJA) to identify guidelines for ethical conduct in a variety of professional areas, including those raised by new health delivery systems. Under the directorship of AMA Vice President for Ethics Standards Linda Emanuel, M.D., Ph.D., the Institute will advance the place of ethics in professional activities. The Institute will augment AMA's traditional ethics activities by initiating conferences and seminars across the country to foster open discussion on the role of ethics and professionalism in today's ever-changing health care environment.

A significant portion of end-of-life care is provided under Medicare and Medicaid, with estimates showing that Medicare and Medicaid beneficiaries account for close to three-quarters of all deaths that occur each year in the United States. Based on the patient populations served by these two programs -- the elderly, the disabled, the poor, and the bulk of the nation's nursing home patients - this is not surprising. While these programs have supported the establishment and expansion of the hospice benefit, end-of-life care for most Medicare and Medicaid patients is provided in hospitals. Under Medicare, hospital coverage is provided through the prospective pricing system based on the appropriate Diagnosis Related Group (DRG) payment amount. HCFA announced last year that it is working with the Milbank Memorial Fund to explore the possibility of establishing a DRG specifically for hospital inpatient care services related to palliative care for "final" illnesses. An ICD-9-CM code has been established and HCFA reportedly will be tracking the results for the next two years before making a final decision. Consistent with this direction, AMA has asked the Current Procedural Terminology (CPT) Editorial Panel to consider the potential for development of CPT codes to better reflect physician services for palliative care.

The AMA unequivocally supports the efforts of Members of Congress who have introduced legislation prohibiting the use of federal funds, such as Medicare or Medicaid monies, for "assisted suicide." [H.R. 4149 and S. 2108 (104th Congress); S. 304 (105th Congress)] We believe that such a prohibition sends a strong message from our elected officials that such acts are not to be encouraged or condoned. The AMA's support relies on the bills' "rules of construction" which acknowledge the appropriate role for physicians and other caregivers in end-

of-life patient care. The legislation properly distinguishes the passive intervention of withholding or withdrawing medical treatment or care (including nutrition and hydration) from the active role of providing the direct means to kill someone. Most important to the educational challenge cited elsewhere in this testimony, the legislation recognizes the medical principle of “double effect,” in which the provision of adequate palliative treatment may sometimes also foreseeably hasten death. This provision assures patients and physicians alike that legislation opposing assisted suicide will not chill appropriate palliative and end-of-life care. Such a chilling effect would, in fact, have the perverse result of increasing patients’ perceived desire for a “quick way out.”

SIGNIFICANT JUDICIAL DECISIONS

Troubling decisions in the Ninth and Second Circuits have held that state laws in Washington and New York prohibiting physician-assisted suicide could not be upheld. Notably, while both decisions were based on constitutional arguments, the constitutional bases cited were different in each case. The United State Supreme Court heard arguments in the appeal of these two cases in January of this year; an opinion is expected in late spring.

In the Ninth Circuit Court of Appeals in California, the panel overruled an earlier finding in the case *Compassion in Dying v. Washington*, finding a constitutional right to physician assisted suicide for terminally ill, competent adults who wish to hasten their death. The ruling concluded

that the Washington state law prohibiting assisted suicide was in violation of the Due Process clause of the U.S. Constitution, as it found a liberty interest in controlling the time and manner of one's death. The AMA had filed an *amicus curae* brief in this case and, while its arguments were discussed in the decision, the Court summarily dismissed the important ethical and practice principles of double effect in pain management as well as the critical distinction between the withholding or withdrawing life sustaining treatment versus physician-assisted suicide.

While the majority opinion dismissed "slippery slope" arguments, a dissenting judge wrote that "[i]f physician-assisted suicide for mentally competent, terminally ill patients is made a constitutional right, voluntary euthanasia for weaker patients, unable to self-terminate, will soon follow. After voluntary euthanasia, it is but a short step to a 'substituted judgment' or 'best interests' analysis for terminally ill patients who have not expressed their constitutionally sanctioned desire to be dispatched from this world." The Washington State Attorney General appealed the decision to the U.S. Supreme Court, and was supported by an *amicus* brief from the AMA and 50 other health organizations.

In the Second Circuit, the Court overturned a decision by a District Court and found New York State laws criminalizing physician-assisted suicide to be unconstitutional. This ruling is more narrowly drawn than the Ninth Circuit decision, as it did not find a constitutional right to assisted suicide. Rather, the Second Circuit found the laws in violation of the Equal Protection clause of the 14th Amendment. The Court's opinion stated that a physician's ability to withdraw life-

sustaining treatment and the ability to administer life-ending measures should be considered as equivalent acts. Any distinction between the two, argued the Court, would deny competent, terminally ill patients who are not on life support the opportunity to end their lives. The AMA likewise supported the New York Attorney General's appeal to the U.S. Supreme Court with an *amicus* brief.

Both decisions are disturbing as they articulate constitutional support for the practice of physician-assisted suicide. Neither decision recognizes the vital clinical distinctions involved in end-of-life care, particularly the administration of pain medication and the use of life-sustaining treatment. Additionally, the decisions counter the ethical requirements of the medical profession, asserting a necessary role for physicians in assisted suicide. The Courts also fail to bring some definition to the concept of a disease's "final stages" or the state of being "terminally ill." Ultimately, these definitions would be crucial in preventing abuse. The Courts also dismissed arguments about the potential social threats of assisted suicide to vulnerable patients in our current health care climate. The Ninth Circuit case is particularly disconcerting in its suggestion that medical ethics is a simple matter for the courts to decide.

Finally, just last week, the Ninth Circuit also dissolved a restraining order preventing the implementation of Oregon's first-in-the-nation law allowing physician-assisted suicide for terminally ill patients. While we expect this decision to be appealed, today's hearing and consideration of legislation barring federal funds directed toward assisted suicide are most timely.

We are no longer in the realm of the hypothetical.

CONCLUSION

The movement for legally sanctioning physician-assisted suicide is a sign of society's failure to address the complex issues raised at the end of life. It is not a victory for personal rights. We are equipped with the tools to effectively manage end-of-life pain and to offer terminally ill patients dignity and to add value to their remaining time. As the voice of the medical profession, the AMA offers its capability to coordinate multidisciplinary discourse on end-of-life issues, for it is essential to coordinate medical educators, patients, advocacy organizations, allied health professionals and the counseling and pastoral professions to reach a comprehensive solution to these challenging issues. Our response should be a better informed medical profession and public, working together to preserve fundamental human values at the end of life.

POLICY OF THE AMERICAN MEDICAL ASSOCIATION
Physician-Assisted Suicide

Policy 140.952 - Physician-assisted Suicide. It is the policy of the AMA that:

Physician-assisted suicide is fundamentally inconsistent with the physician's professional role.

It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.

Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.

Requests for physician-assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.

Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. (CEJA Rep. I-93-8)

Policy 140.966 - Decisions Near the End-of-life. The AMA believes that:

The principle of patient autonomy requires that physicians must respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics and artificial nutrition and hydration.

There is no ethical distinction between withdrawing and withholding life-sustaining

treatment.

Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time. (CEJA Rep. B, A-91)

OPINIONS OF THE AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

Opinion 2.17 - Quality of Life. In the making of decisions for the treatment of seriously disabled newborns or of other persons who are severely disabled by injury or illness, the primary consideration should be what is best for the individual patient and not the avoidance of a burden to the family or to society. Quality of life, as defined by the patient's interests and values, is a factor to be considered in determining what is best for the individual. It is permissible to consider quality of life when deciding about life-sustaining treatment in accordance with Opinions E-2.20, E-2.215, and E-2.22. Updated June 1994; Issued March 1981. (I, III, IV)

Opinion 2.20 - Withholding or Withdrawing Life-Sustaining Medical Treatment. The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. The principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decisionmaking capacity. Life-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

There is no ethical distinction between withdrawing and withholding life-sustaining treatment. A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make such a decision.

If the patient receiving life-sustaining treatment is incompetent, a surrogate decisionmaker should be identified. Without an advance directive that designates a proxy, the patient's family should become the surrogate decisionmaker. Family includes persons with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are persons who both care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates. Physicians should provide all relevant medical information and explain to surrogate decisionmakers that decisions regarding withholding or withdrawing life-sustaining treatment should be based on substituted judgment (what the patient would have decided) when there is evidence of the patient's preferences and values. In making a substituted judgment, decisionmakers may consider the patient's advance directive (if any); the patient's values about life and the way it should be lived; and the patient's attitudes towards sickness, suffering, medical procedures, and death. If there is not adequate evidence of the incompetent patient's preferences and values, the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being).

Though the surrogate's decision for the incompetent patient should almost always be

accepted by the physician, there are four situations that may require either institutional or judicial review and/or intervention in the decisionmaking process: (1) there is no available family member willing to be the patient's surrogate decisionmaker, (2) there is a dispute among family members and there is no decisionmaker designated in an advance directive, (3) a health care provider believes that the family's decision is clearly not what the patient would have decided if competent, and (4) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. When there are disputes among family members or between family and health care providers, the use of ethics committees specifically designed to facilitate sound decisionmaking is recommended before resorting to the courts.

When a permanently unconscious patient was never competent or had not left any evidence of previous preferences or values, since there is no objective way to ascertain the best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decisionmaker's true concern for what would be best for the patient.

Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. Even if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of life-sustaining medical treatment in accordance with a proper substituted judgment or best interests analysis. Issued March 1981 (Opinion E-2.11: Terminal Illness) and December 1984 (Opinion E-2.19: Withholding or Withdrawing Life-Prolonging Medical Treatment: Patient's Preferences, renumbered as Opinion E-2.21 in August 1989). (I, III, IV, V)

Opinion 2.211 - Physician Assisted Suicide. Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress, such as those suffering from a terminal, painful, debilitating illness, may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. Issued June 1994 based on the reports "Decisions Near the End of Life," issued June 1991, and "Physician-Assisted Suicide," issued December 1993. (I, IV)